Unofficial Copy 1997 Regular Session
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**By: Senator Astle**
Introduced and read first time: January 31, 1997
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

**Health Maintenance Organizations - Payment of Nonparticipating Health Care Providers - Medicare Contracts**

FOR the purpose of exempting a health maintenance organization from a certain prohibition against the use of a certain methodology to determine the rate of payment to a health care provider that is not under contract with the health maintenance organization, if the services of the provider are rendered under a certain federal Medicare contract; and generally relating to provider payment methodology used by health maintenance organizations.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-710.1
Annotated Code of Maryland
(1996 Replacement Volume and 1996 Supplement)

Preamble

WHEREAS, Section 19-710.1 of the Health - General Article requires HMOs to file with the Maryland Insurance Administration the schedule of fees which the HMO pays to providers not under written contract for services rendered to members of the health maintenance organization; and

WHEREAS, The fee schedules must be based on the usual, reasonable, and customary payments for similar claims; and

WHEREAS, Section 19-710.1 permits an HMO to base Medicaid fee schedules on fees for claims to the U.S. Health Care Financing Administration for services rendered under the Medicaid program; and

WHEREAS, Fee schedules for services rendered to HMO members in the Medicare program should similarly be permitted to be based on U.S. Health Care Financing Administration Medicare fees and the rates paid to HMOs for those services; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

**Article - Health - General**

19-710.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Enrollee" means a subscriber or member of the health maintenance organization.

(3) "Covered service" means a health care service included in the benefit package of the health maintenance organization and rendered to an enrollee of the health maintenance organization by a health care provider, including a physician or hospital, not under written contract with the health maintenance organization:

(i) Pursuant to a verbal or written referral by the enrollee's health maintenance organization or by a provider under written contract with the enrollee's health maintenance organization; or

(ii) That has been preauthorized or otherwise approved either verbally or in writing by the enrollee's health maintenance organization or a provider under written contract with the enrollee's health maintenance organization.

(4) "Adjunct claims documentation" means an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee.

(b) (1) In addition to any other provisions of this subtitle, for a covered service rendered to an enrollee of a health maintenance organization by a health care provider not under written contract with the health maintenance organization, the health maintenance organization or its agent:

(i) Shall pay the health care provider within 30 days after the receipt of a claim in accordance with the applicable provisions of this subtitle; and

(ii) Shall pay the claim submitted by:

1. A hospital at the rate approved by the Health Services Cost Review Commission; and

2. Any other health care provider at the rate billed or at the usual, customary, and reasonable rate.

(2) A health maintenance organization that pays a health care provider at the usual, customary, and reasonable rate:

(i) Except for services rendered to medical assistance recipients OR FOR SERVICES RENDERED UNDER A CONTRACT ENTERED INTO UNDER § 1876(G) OF THE FEDERAL SOCIAL SECURITY ACT (42 U.S.C. § 1395MM), may not use Medicare, Medicaid, or workers' compensation payments as part of any methodology used to determine a payment at the usual, customary, and reasonable rate; and

(ii) On request of the health care provider, shall disclose the methodology used to determine the amount of payment.

(c) (1) A health maintenance organization may seek reimbursement from an enrollee for any payment under subsection (b) of this section for a claim or portion of a claim submitted by a health care provider and paid by the health maintenance organization that the health maintenance organization determines is the responsibility of the enrollee.

(2) The health maintenance organization may request and the health care provider shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (b) of this section.

(d) In addition to any other penalties under this subtitle, the Commissioner may impose a penalty not to exceed $5,000 on any health maintenance organization which violates the provisions of this section if the violation is committed with such frequency as to indicate a general business practice of the health maintenance organization.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1997.